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ABSTRACT

The general societal pattern in Malaysia is reflected by the distinct multi-racial composition of the population, comprised of Malays, Chinese, and Indians. In Malaysia, ethnicity determines the varied differences in the socio-cultural and religious diversity of the population. Organized modern medical services have existed in Malaysia since before independence from Great Britain in 1957 and include services for the mentally ill. Medical psychiatric training had its beginning in 1966; counselor education began in 1976. Shortages of trained personnel exist in mental health care. In Malaysia a sophisticated framework of folk healers for both physical and mental illness exists. Central to the structural system of traditional medicine in Malaysia are the bomoh among the Malays; the sinsehs among the Chinese; and the pujaris among the Indians. Common factors in the Malaysian folk therapies are identified by some central dominant element such as the semangat among the Malays; the yin-yang among the Chinese; and the tridosas among the Indians. Other aspects of the folk therapies are warmth and acceptance in the therapeutic relationship, the arousing of emotions, self-mastery, and the raising of hope and motivation to facilitate change in the patient's behavior. The "main puteri" rites are a form of indigenous Malay psychotherapy which involves an elaborate process of preparation for the client as well as the environment which incorporates the client's immediate family. Treatment procedures are usually applied as a psychotherapy for depression. This is a group process procedure which incorporates support from the patient's family and role playing techniques reminiscent of psychodrama. (Author/ABL)

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CROSS-CULTURAL PERSPECTIVES IN COUNSELING: MENTAL HEALTH CONCEPTIONS IN MALAYSIA

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Abstract

The paper addresses various mental health conceptions of the three main ethnic groups in Malaysia - the Malays, the Chinese, and the Indians. The history of organized mental health facilities and the training of psychiatrists and counselors in Malaysia are described. Central to the structural system of traditional medicine in Malaysia is the bomoh among the Malays; the sinsehs among the Chinese and the pujaris among the Indians. Common factors in the Malaysian folk therapies are identified by some central dominant element such as the semangat among the Malays; the yin-yang among the Chinese and the tridosas among the Indians. Other aspects are warmth and acceptance in the therapeutic relationship, the arousing of emotions, self mastery, the raising of hope and motivation to facilitate change in the patient's behavior. The main puteri as one form of the indigeneous Malay psychotherapy is described with treatment procedures usually applied as a psychotherapy for depression. The main puteri as a group process procedure incorporates support from the patient's family and role playing techniques reminiscent of psychodrama.

Mental Health Conceptions in Malaysia

The Socio-Cultural Pattern in Malaysia

Malaysia is located along the crescent of the Malay archipelego within the geographical region of Southeast Asia, with 11 states of the country on the Malay peninsula and the states of Sabah and Sarawak on the island of Borneo. The general societal pattern in Malaysia is reflected by the distinct multi-racial composition of the population. The estimated 14.7 million population comprises of 48% Malays, 31% Chinese, 8% Indians. The minority groups of Ibans, Bidayuh, Melanaus, Kadazan, Bajaus represents 10%, mainly populating the states of Sabah and Sarawak. The aboriginal subgroups and others represents the remaining 3% of the population (Malaysia Official Yearbook, 1984).

In Malaysia, ethnicity determines the varied differences in the socio-cultural and religious diversity of the population. Islam is the religion of the Malays. The way of life of the Malays is in general the product of its responses to the challenges of its environment (S. Husin Ali, 1966). A majority

of the Chinese are either Buddhist or Taoist, though there are some who are Christians or Muslims. The Chinese in Malaysian society have their greatest concentration in the urban areas. Even among the Chinese population there are several communities such as the Hokkien, the Teochiu, the Cantonese, the Hakka and the Hainanese, each community sharing exclusive association and bound by clan values and co-operation. Like the Chinese, the Indian community is not homogeneous. Heterogeneity is identified mainly by the language that is spoken. The majority of the Indian community however professes the Hindu religion with a minority professing either Christianity or Islam (Ryan, 1971). The minority groups too are not homogeneous culturally in their specific ethnic groupings. For example, on the basis of religious differences, Ibans are either Muslims, Christians, Buddhist or adhere to the animist traditions. Any observations of the Malaysian socio-cultural perspective must be made with cautious analysis, more so since the implementation of the various government policies to restructure society there has been changes

in societal patterns affecting the values and norms of the various communities.

Nevertheless despite the changing value patterns Malaysians still adhere to many of the traditional mores in the conduct of their daily activities. Among the common customs that still persists within the changing societal environment is their strong belief of the causation and treatment of mental illness. It is in this context that this paper shall address regarding the varied mental health conceptions of the three main ethnic groups in Malaysia, the Malays, the Chinese, and the Indians.

Organized Mental Health Facilities

Organized pattern of modern medical services have existed in Malaysia even before independence of the country from Great Britain in 1957. Inclusive within this medical services were organized facility for the care and treatment of the mentally ill. In 1829, an organized psychiatric facility was initiated in Penang (Ward & Grant, cited in Tan & Wagner, 1971). The facility was subsequently transferred to Tanjong

Rambutan where in 1911 a Central Mental Hospital was established. In 1935, another hospital catering for psychiatric patients were constructed at Tampoi. By 1971, the country has 7,500 psychiatric beds available, made up of 4500 in the Central Mental Hospital, Tanjong Rambutan; about 2500 in the Tampoi Mental Hospital, Johor Bahru; about 350 in the Kuching Mental Hospital, Sarawak and about 50 beds in the Buli Sim Sim Hospital, Sandakan, Sabah (Tan & Wagner, 1971).

Besides the care and the treatment of the mentally ill at the four hospitals, outpatient psychiatric clinics are also currently available in several of the government sponsored general hospital in the major towns. The first was opened in the General Hospital Penang in 1959 and since that year other units have been opened in the General Hospitals of Alor Star, Kota Bharu, Seremban, Sungai Petani, Johor Bahru, Taiping. Since 1967, the University of Malaya Medical Center has also provided psychiatric facility in Kuala Lumpur (Tan & Wagner, 1971).

Evidently, the facilities in the major towns requires patients in the remoter areas of the country

to travel long distances which at times may take several days. Moreover, there exist a shortage of trained psychiatrist and counselors in Malaysia. In 1962 there were only ten trained psychiatrist. In 1971, the ratio of psychiatrist to the general population was approximately one psychiatrist to one million people (Chen, 1971).

Medical psychiatric training in Malaysia had its beginnings in the University of Malaya Department of Psychological Medicine in 1966 (Tan & Wagner, 1971). Nevertheless, it was not until 1976 that formal counselor education program was initiated at the university. Since then three other universities, and a specialist teachers training institute have offered programs in guidance and counseling (Lloyd, 1987; Othman, 1987). Nevertheless graduates completion from these programs are still minimal. It may take between 15 to 50 more years before an optimal composition of trained mental health personnel are readily available, consistent with the changing pattern and increasing rate of population growth in the country.

Implications for such shortages of trained personnel in mental health care assumes either patients in the rural areas are devoid of such facilities or there exist a folk support system that deals with mental health of the population, especially in the rural areas of the country.

The latter seems to be true in Malaysia where a sophisticated framework of folk healers for both the physical and mental illness exists.

Background of Traditional Folk Medicine in Malaysia

The diversity of the multi ethnic population in Malaysia is also reflected by the varying traditional folk medicine practiced by the various ethnic groups. The traditional medicine of the Malays are influenced by the varied forces that mould its culture. Animistic beliefs, Hindu customs are still prevalent in a now predominantly Islamic Malay society. Westernization has also seen its influence in the socialization of the Malays, although its impact is quite superficially spread out on their societal mores and customs.

Central to the structural system of the traditional Malay medicine is the bomoh. The bomoh is the Malay folk healer who is culturally sanctioned by Malay society as having the power to control the supernatural and subsequently to assist in the healing process of the patient. The treatment process may be in the form of personal communication, acts, rituals and prescriptions of specific herbal concoctions. Being culturally sanctioned, his position is further reinforced by his knowledge of traditional causation of diseases, treatment and its prevention (Chen, 1971).

The migration of the Chinese into the Malay Peninsula and subsequent involvement with Malay society in the 19th century brought about a new dimension of folk traditional medicine in the country. Classical Chinese medicine dates back at least 4000 years and is primarily based on the concepts of the two opposing elements in cosmic forces, the yin and yang. Accordingly, the yin and yang must remain in harmony in the body to promote health. The Chinese folk healers, the sinsehs, who practices Chinese medicine in Malaysia

primarily design the treatment process towards curing the yin-yang imbalance.

As with Chinese migration to Malaysia during the 19th century, similar mass migration of the Indians into the Malay Peninsula during the same period brought along a tradition of Indian medicine with a history stretching to about 2000 BC. The system of traditional Indian medicine as practiced in Malaysia is perhaps complex since it incorporates several branches of classic Indian medicine inclusive of Ayurvedic medicine, Siddha medicine and Homeopathy. Originally only the Brahmins priests were qualified to be the folk healer. This practice however has demise and at present temple keepers called pujaris may also be curers, mediums, using a variety of treatment techniques inclusive of herbal remedies (Colley, 1978).

Traditional Mental Health Concepts in Malaysia

The Malays

Although the Islamic religion has an impacting influence in the lifestyle of the Malays, the influence of pre-Islamic beliefs are still evidently strong.

Islamic theology too has provided the flexibility of acceptance among the Malays towards the reality of the spirit world. Islamic theology provides for the existence of both man and the spirit world specifically the jin which are beings existing in an invisible form. Hence, such belief perceptions of the Malays renders easily the interaction of common folk beliefs in regard the spirit world with Islamic practices.

The spirit world as perceived by the Malays are either benevolent as depicted by the jin Islam, or malevolent, more categorized by the hantu, syaitan, iblis. Indigenous Malay medicine made no clear cut distinction between mental and physical illness. Illness are regarded as involving the individual person in his entirety and the person's interaction with the environment as well as with the spirit world. Chen (1970, 1979), indicated that the Malay conception of mental illness is the result of three factors namely physical causes, supernatural causes, and predisposing conditions.

Physical causes of mental illness constitutes brain impairment states, such as epilepsy - gila babi.

Senility - nyanyok is also ascribed to brain impairment. Latah - a Malay culture bound syndrome is associated with echolalia. The predisposing condition for the cause of latah is catalyzed when a person is suddenly stimulated. The Malays believe that Semangat or the soul substance has a primary function in the mental and physical health being of an individual. The semangat is the central concept in the Malay perception of the internal force or the acceptance of existence of both animate and inanimate elements. For a person, it gives him a sense of strength, the source of wellness and confidence.

There also exist the concept of angin - wind, which is related to certain food substances which will cause flatulence when taken by a healthy person. Such food substances that have angin when consumed by a person with a loss of semangat may be manifested by vertigo effects.

Blood conditions too are believed to influence the mental well being of a person. Darah kotor - bad blood, blood clots are believed to be the causes of mental states of acute migraine headache, insomnia,

anxiety depression, fainting fits. The method of bekam is believed to be an effective treatment for acute headache, insomnia. The treatment involves minor incisions of certain parts of the body especially the nape of the neck and the darah kotor is then drawn out via capillary action using specific cone containers usually made from the tip of the horn of the buffalo.

Supernatural agents are also purported to be the causes of certain mental illness. Insanity, psychoses - gila is a conceptual term that includes all severe disorganizing mental states (Chen, 1970; Resner & Hartog, 1970). Mereng, sasau, are used to describe people who are neurotic, emotionally unstable. Gila is then given sub classifications of gila kena hantu, gila dirasuk hantu - insanity caused by malevolent spirits. The symptoms includes fits of violence, auditory hallucinations and superhuman ability of physical destruction. Gila buatan orang - insanity caused by witchcraft. Gila isim - insanity caused by mental strain and excessive concentration. The gila isim is also caused by excessive concentration and combination of learning contradictory knowledge between the

practices of Islam and non-Islamic practices. Gila mengamok - amok is a Malay culture bound syndrome where there is a sudden unprovoked outburst of rage that causes the affected person to run wildly and attack or kill any person in his path indiscriminately. Usually the affected person is armed. The condition is ascribed as being an extreme form of insanity caused by malevolent spirits.

Susceptibility to severe mental stress are more associated with the loss of semangat which is a predisposing condition. Risau, rungsing, susah hati, are various forms of anxiety more related to the inability of the mind to conform to logical problem solving tasks. Such anxiety states are the precursors of severe mental stress which may result in depression - rasa moyok.

The semangat being the central force in Malay perception of inner strength and well being is therefore given an exceptional care in each individual. For the Malay, the semangat is sensitive, timid, yet caters for the goodness, and helpfulness of the individual. Such sensitivity are more prevalent among

infants and children who are believed to have weaker semangat than adults. In Malay child rearing custom, caution is especially catered not to suddenly excite the infant or child with fear. If such fearful surprises and excitement occurs it may weaken the semangat and thus conditioned the infant or child with weaker semangat upon being an adult. Such weakness then becomes a liability for the individual, for any person who suffers from lemah semangat, kurang semangat, hilang semangat, or weak, shortage, loss of the soul substance respectively is easily liable to illness.

The Chinese

In Malaysia, the Chinese regarded mental health illness as a mixture of organic illness and mystical possession. The Chinese believe in a pantheon of many powerful deities and spirits. It is their belief that the deities and spirits can be influenced for the advantage of man through the process of specific rituals. Generally the ritual processes have to be conducted through an intermediary in the person of the spirit medium.

Among the Chinese, concepts of heat, cold and wind are used to described the etiology of illness. Mental disorders are described as wind madness, ghost evil, anxiety as a result of wind affecting the five organs, anxiety occupation, convulsion madness, and madness of childbirth (Gwee, 1971). There are concepts of predispose conditions which leads to mental disorder. Such classification relates to excessive happiness, excessive anger, excessive anxiety, excessive preoccupation of certain thoughts - sorrow, sadness, fear, fright (Kinzie, Teoh, & Tan, 1976).

Central to the Chinese perception of good health is the yin-yang balance, that has to be in harmony in the body of an individual. Any imbalances may affect both the mental and physical functioning of an individual. A system of meridian is also conceptualize as being in control of an individual's health. The meridians are influenced by the circulation of the animus in accordance to the seasonal and diurnal changes. Subsequently, mental illness is believed due to the spirit possession of the person causing impurities and imbalance of the organs especially the

heart and circulation. Anxiety is caused by the wind spirit, thus affecting imbalances in the major bodily organs, and weakness in the blood spirit results in convulsion madness.

Organic imbalances are related to the instability of the heart and circulation imbalance is a consequence of blockage of circulation of the meridians. Generally since mental illness is regarded as an ailment of the heart, treatment by the sinseh is directed towards stabilizing the organ. The technique of acupuncture is usually used to restore the meridian circulation (Gwee, 1971).

The Indians

In Malaysia, the Indians mainly profess the Hindu religion. In the Malaysian setting, Hinduism exists at two levels specifically the transcendental complex system and the pragmatic complex system. Colley (1978), indicated that primarily the transcendental complex system ensures the long term welfare of the society. With the social support institutions, the system ensures an individual's proper movement from one stage to another stage in his lifecycle. Thus being

more related to the general overall society, the transcendental complex is centered upon major Hindu temples where the great deities of the Hindu pantheon are worshipped. The pragmatic complex system is a lesser religious entity more employed for overcoming the mundane problems of everyday life. Locality of the shrines of the pragmatic complex system varies and are found widely spread out in the villages, wayside streets; all for the purpose of daily worshipping of the household and village deities.

There is a close relationship between deity worship and spiritual healing. Pujaris who are temple keepers under the pragmatic complex are also diviners, exorcists, spirit mediums, and curers involved in therapeutic advice. These process occurs when clients are able to converse with the spirits through the pujari during the medium trance.

In ayurvedic medicine, the doctrine of the three humors - tridosas is central to the diagnosis and treatment of diseases. The humors vata - wind, pitta - bile, kapha - mucous and rakta - blood supports the bodily functions. The humors are not static and

continually adjust amongst themselves in a changing environment ensuring the health of an individual. Ayurveda is concerned with harmonizing both the secular and spiritual pursuit of the individual. This is realized through the relationship between the bodily functions, the mind, the soul and the universe. In this regard, the health of an individual is conceptualized as being an equilibrium of the tridosas as well as the spiritual stability of the individual.

Common Factors in Malaysian Folk Therapies

The Malays, Chinese and Indian mental health conceptions are depicted by the various classifications and symptomatology of mental health illness within the specific ethnic group. Conceptions of both physical and mental health are governed by some central dominant element. Among the Malays, the semangat exist as the sensitive element that needs nurturance for the well being of the individual. The Chinese yin-yang principles needs to attain the balance for optimum bodily functioning. The ayurvedic equilibrium of the tridosas with spiritual stability are persistent health

components among the Indians. Indeed, these specific conceptions forms the basic therapeutic implementation process of the folk therapy.

The folk healers have a wide range of technical skills and sophistication of understanding the causation and prognosis of the client's mental illness. The Malay bomoh, the Chinese sinseh, the Indian Brahmin priest conduct the process of their interaction with their clients through specific human relationship skills depicting warmth, acceptance and being non-defensive. The folk healers communication skills goes beyond the ordinary interactional accomplishments; the bomoh, the Chinese temple medium, the pujari's ability to communicate with the spirit world heightens the emotionality environment of the therapy relationship.

Nevertheless, the sophistication of their techniques varies. Though there are commonalities, there are differentiation in the treatment process since not all the bomohs are the same nor are the Chinese sinsehs, or spirit mediums, or the Indian pujaris (Kinzie, Teoh, & Tan 1976). Some of the treatment process besides verbalization techniques may

incorporate bathing, oil massages, prayers, jampi - incantations and herbal concoctions.

In the main puteri rites as an approach in one form of the indigenous Malay psychotherapy, the treatment procedures undergoes an elaborate process of preparation for the client as well as the environment, incorporating the client's immediate family. The main puteri has been successfully used as a psychotherapy for depression in Malaysia (Chen, 1979).

The main puteri can be depicted as a group process procedure with initial preparation of the gelanggang - the platform where the therapy rites takes place. The preparation of the gelanggang is a group effort performed by the client's family. Mengkuang mats are placed on the gelanggang floor before the rites begins, usually with a small kenduri - feast and subsequently an initial intervention interview of the client by the bomoh to determine the significance of the client's complaints.

The rituals of the main puteri involves the preparation of the pengeras guru - offerings to the patron of the main puteri as an initiation of the

healing ceremony. Sitting positioning of the participants in the main puteri inclusive of the client are very specific. The bomoh assumes a central position facing north with the client towards his left facing east; the minduk who is the master of the spirit of the main puteri is on the right of the bomoh, facing west. A troupe of six musicians sits in front of the bomoh providing the rhythm during the ceremonial rites. The minduk functions as an intermediary between the spirit and the bomoh who when possessed by a suitable spirit will provide the diagnosis of the sources of the illness confronting the client.

The therapy process in the main puteri besides jampi - incantations, involves permainan peranan - role playing by the client which is considered to be a crucial element if the spirits are to be satisfied. It is not uncommon for the client through persuasion and suggestion to perform strong roles such as a king, a tiger, a warrior with the bomoh in the role of the court jester during his trance (Chen, 1979). Such role playing enactments reminiscent of psychodrama

techniques allows the client to command the central character in the main puteri.

Being the central figure gives the client eminence and heightens feelings of self worth. This is further reinforced through the knowledge that the main puteri which involves expenditure are being supported by the family and immediate relatives. The group solidarity reminiscent of the role playing effort and participation of the family helps to reintegrate the client in his interpersonal relationships. The main puteri helps draws out the client from his internal absorbtion, reinforced by his feelings of self worth (Chen, 1979). In fact, the encouragement and support motivates the client's expectations for change, creating hope and an opportunity to work on the problem towards some desired outcome. The rituals are set in a manner that is culturally acceptable and understandable to the client. Such acceptability provides a sense of conceptual framework on the part of the client's ability to reintegrate what was previously some chaotic thinking. The role playing of strong characters, various interpretation by the bomoh and information

giving through the *minduk* provides a new learning experience for the client, enhancing a sense of mastery. Such observations seems to concur with common elements that promotes growth and change in other form of therapies following the modern approaches (Garske & Lynn, cited in Lynn & Garske, 1985).

Conclusion

The traditional psychotherapies in Malaysia are a logical consequence of the mental health conceptions of the specific ethnic groups. The development and imbalances of the Malay *semangat*, the Chinese *yin-yang*, and the Indian *tridosas* equilibrium with spirituality are central elements in the indigenous mental health conceptions and approaches to therapy. The common elements observed in the indigenous psychotherapies are somewhat similar with modern approaches in aspects of relationships, the arousing of emotions, self mastery, the raising of hope and motivation that facilitate changes in behavior in the client.

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